AACVPR Update for

Tom Draper, MBA, FAACVPR
President, AACVPR
Mission

To reduce morbidity, mortality, and disability from cardiovascular and pulmonary disease through education, prevention, rehabilitation, research, and disease management.
Membership

- Membership 3,300+
- State Affiliates: 40+
- Joint Affiliates: 15
- Masters & Fellows: 400+
Education

- Virtual and in-person on:
  - Exercise Prescription
  - Behavior Change
  - Cardiovascular Rehab and Clinical Cardiology
  - Leadership & Innovation
  - Nutrition
  - Program Management
  - Pulmonary Rehab & Medicine
EXERCISE PRESCRIPTION MODULES

Pre-Exercise Assessment
Developing the Exercise Prescription
The Exercise Session
Telemetry
STAFF COMPETENCIES FOR CORE COMPONENTS

Four new modules

• Diabetes Management NEW
• Tobacco Cessation NEW
• Psychosocial Management NEW
• Weight Management NEW
• Cardiac Exercise Training
• Pulmonary Exercise Training
• Patient Assessment

Discounted member pricing & bundles at aacvpr.org
Publications

- JCRP
- Guidelines & Resources (aacvpr.org)
- News & Views
Advocacy

• Day on the Hill (DOTH)
• Regulatory & Legislative Information
• Health Policy & Reimbursement
• Medicare Administrative Contractors (MACs)
PAD: CMS Proposed Coverage Policy

• Up to 36 sessions (30-60 min) of 3 sessions/week over 12 weeks
• Program must be conducted in hospital or outpatient hospital setting
• Personnel must be trained in ALCS and exercise therapy for PAD patients
• Must be under direct supervision of MD
• Patient must have face-to-face evaluation with responsible MD to obtain PAD program referral
AACVPR Program Certification

Identify your program as a leader.

Learn more at www.aacvpr.org.
478 Subscribed Programs

220 Subscribed Programs

www.aacvpr.org/Registry
Professional Certification

The *only* professional certification specific to cardiac rehabilitation.

Earning this certification demonstrates mastery of the core components essential in providing quality cardiac rehabilitation.
CHANGE IS COMING. BE PREPARED.

ROADMAP TO REFORM

aacvpr.org/R2R
Episode Payment Models
Continuum of Payment Models

The Future is Now

**Fee For Service**
- Pay for volume
- No quality measured

**Value-Based Payment**
- Quality per click
- Process improvement

**Care Coordination**
- Quality outcomes of episodes
- Whole system improvement

THEN \[\rightarrow\] NOW \[\rightarrow\] FUTURE
CV Care is no longer provided in silos – Shifting to episodic continuum of care
“Episode Payment Models” (EPM) for AMI and CABG

Cover the period from hospital admission through and including 90 days after discharge.

The bundled payments will be for “fee for service” Medicare patients (not Medicare Advantage plans) with these diagnoses and will be implemented in 98 Metropolitan Service Areas (MSAs) across the country.
• Target price CMS will reimburse is set on blend of hospital-specific & regional historical data
• If care provided is below quality-adjusted target price, participant hospital receives savings
• Hospitals with costs exceeding target price will repay Medicare
• Exciting incentive program intended to increase referral to and participation in cardiac rehabilitation programs for patients with AMI and CABG.

<table>
<thead>
<tr>
<th>Sessions</th>
<th>Incentive</th>
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<tr>
<td>1-11</td>
<td>$25</td>
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<tr>
<td>12-36</td>
<td>$175</td>
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• 90 MSAs included in this particular incentive program - 45 of which come from the “bundled payment” MSAs and 45 from all other eligible MSAs not chosen to participate in the bundled payment model.
Bundled Payments “Algorithm”

294 MSAs

98 MSAs
Chosen for AMI/CABG bundle

196 MSAs
Not chosen for AMI/CABG bundled payment

45 MSAs
Also in CR incentive

53 MSAs
Not in CR incentive

45 MSAs
In CR incentive

151 MSAs
Not in CR incentive or AMI/CABG bundle
Selected MSAs for EPM/CRI: Minnesota

- **Duluth**  
  (Incentives only)

- **Rochester**  
  (Incentives only)
Primary Goals

To understand whether and how the effects of a financial incentive for use of CR/ICR services differ depending on whether a beneficiary’s care is covered under bundled payment or FFS.

To examine each intervention’s separate effects on quality and efficiency of care beneficiaries receive.
CR effects on AMI/CABG outcomes important to CMS will be examined, such as:

1. Hospital readmission rates
2. HCAHPS patient satisfaction scores
3. Mortality
4. Amount of care deferred beyond the 90-day post-hospital discharge episode
5. Most Importantly - Cost Savings
Cardiac Patient Benefits

- Increased access to CR programs
- Earlier engagement in CR programs and more immediate support post-hospital discharge
- Incentive payment can be used to directly benefit the patient (e.g., transportation support)
- Coordinated and more satisfactory care
- Improved patient outcomes with better care through lower cost
• Increased referrals to CR programs
• Increased awareness of CR
• For some, financial benefit with two-tiered incentive payments in addition to customary reimbursement for CR services
• Increased opportunities for your program to design and implement innovative practice models – and better integrate into CV services

Depending on which group your program falls into, and what role you play, you must take some concrete steps in order to prepare for this new reality.
What does this mean for me?
Cardiac Rehab is the Best SOLUTION for High Quality, Efficient Cardiovascular Care Across the Continuum.

www.aacvpr.org/R2R
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Necessity is the Mother of Invention.

- English Proverb
What is Your Role?

- Articulate Patient Benefits
- Talk to your Docs
- Share the Data
- Understand Financial Impact
- Obtain Administration Buy-In
Articulate Patient Benefits

- Improved functional capacity
- Increased knowledge of heart disease
- Improved adherence to positive lifestyle changes
- Enhanced compliance with medical regimen
- Increased self-esteem and confidence
- Reduced subsequent morbidity & mortality
- Improvement in cardiac psychosocial risk factors
Financial incentive to enroll patients in CR
58% relative risk reduction in mortality at 1 yr (34% at 5 yrs)
Benefit is “dose dependent” (more CR = better outcomes)
Automatic referral need to reduce D2P (Class 1 indication NQF Quality Measure)
CR cost effective and least costly disease management model
Incorporates evidence-based practice guidelines
CR is your **partner** for med compliance, lifestyle modification for CV risk reduction, patient education and satisfaction (CGCAPH S)
Reduces re-hospitalization rates
Reliable surveillance for improved clinical outcomes
Enhanced access to physician services
CR is underutilized - need to increase referrals
- Decreased all-cause mortality (15-28%)
- Reduced risk of fatal MI (≥ 25%) / cardiovascular mortality (26-31%).
- Decreased severity of angina & need for anti-angina medications
- Decreased re-hospitalizations (31%)
- Decreased cost of physician office visits & hospitalizations (≤35%)
- Fewer ER visits
- Decreased cardiac event rates
- Understand your program’s data
<table>
<thead>
<tr>
<th></th>
<th>Primary Operational Target: Enrollment = EN Efficiency = EFF</th>
<th>Bundle + Incentive</th>
<th>Bundle Only</th>
<th>Incentive Only</th>
<th>Neither</th>
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<tbody>
<tr>
<td>1. Decrease discharge to start time (i.e., early enroll)</td>
<td>EN</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>++*</td>
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<tr>
<td>2. Group orientation</td>
<td>EN and EFF</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>++*</td>
</tr>
<tr>
<td>3. ECG telemetry use (as needed)</td>
<td>EN and EFF</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>++*</td>
</tr>
<tr>
<td>4. Exercise blood pressure (as needed)</td>
<td>EFF</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
<td>++*</td>
</tr>
<tr>
<td>5. Accelerated CR</td>
<td>EFF</td>
<td>++++</td>
<td>++</td>
<td>++++</td>
<td>++*</td>
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<tr>
<td>6. Incorporate Home-Based CR = Hybrid CR</td>
<td>EN and EFF</td>
<td>++</td>
<td>+++</td>
<td>++</td>
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## Four (Five) Potential Strategies to Improve Enrollment and Efficiency in CR

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Increase Enrollment</th>
<th>Program Efficiency</th>
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<tbody>
<tr>
<td>1. Automatic referral with liaison</td>
<td>++++</td>
<td>+</td>
</tr>
<tr>
<td>2. Group orientation</td>
<td>++</td>
<td>+++</td>
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</tr>
<tr>
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<td>+++</td>
<td>++</td>
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<tr>
<td>5. Optimizing gains in functional capacity</td>
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Understand Your Cardiac Rehab Department’s Profit and Loss and the additional financial benefits:

- *Improvements in quality*
- *Decreasing overall costs*
- *Readmission penalty avoidance*
- *Downstream revenue*
- *Additional revenue streams*
• Share an aspirational vision of your program
• Outline benefits to the hospital or system
• Articulate the *win-win scenario* to the service line

• The hospital or system will be willing to seek opportunities for your program to grow and expand
  • *More marketing and outreach resources*
  • *Internally promote and highlight your program as a solution*
• Be willing to invest capital resources in your program

Early buy-in ➔ Success
Keys to Success

Be open to change

Refer to, and share, best practices

Re-design program to accommodate more patients

Stay informed (AACVPR website, webinars, regional workshops and Reimbursement Updates)

Educate Your Team
WHAT CAN YOU DO?
WE ASK THAT YOU **E.M.B.R.A.C.E.** THE UPCOMING CHANGES!

**E** — **ENGAGE** with AACVPR, your facility leadership, and your staff to evaluate what you can do.

**M** — **MANAGE** expectations. These changes are coming quickly.

**B** — **BE BOLD** and be brave. This is your opportunity to play a role in improving patient health.

**R** — **RESOURCEFULNESS** is key. Be creative with your thoughts about how to meet this new challenge head-on.

**A** — **ACCOUNTABILITY** as we realize this is the new normal. We are responsible for responding accordingly.

**C** — **COMMUNICATE** with AACVPR. Help us understand your needs.

Q + A

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